SECTION 9
MATERNITY CARE AND DELIVERY

GLOBAL POLICIES

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides all the patient's obstetric care. For this purpose, a physician group is defined as an obstetric clinic, provider type "50", there is one patient record and each physician/nurse practioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as services occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery, and postpartum care. The clinic may elect to bill globally for all prenatal, delivery, and postpartum care services provided with the clinic, using the primary care physician's provider number as the performing provider.

Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, care for pregnancy related conditions (e.g. nausea, vomiting, cystitis, vaginitis), and the completion of the *Risk Appraisal for Pregnant Women* form. Only one prenatal care code, 59425 (four-six visits) or 59426 (seven or more visits), may be billed per pregnancy. The date of the delivery is the date of service to be used when billing the global prenatal codes. If a provider does more than three visits but the recipient goes to another provider for the rest of her pregnancy, all visits must be billed using the appropriate office visit procedure codes.

Billing for global services cannot be done until the date of delivery.

EXEMPTED VISITS/CONSULTATIONS

A total of two visits may be reimbursed by Medicaid to the initial provider (who is not the provider of ongoing care) to establish a pregnancy, perform an initial examination, and make a referral to a second provider. For example, many recipients utilize the services of a local health agency to establish their pregnancy which then refers them elsewhere for continuing care for their pregnancy. Therefore, if the recipient sees another provider for no more than two visits for her pregnancy, the provider of ongoing care is allowed to bill global.

In addition, two consultations may be reimbursed by Medicaid to another provider. The referring provider may still bill global.

RISK APPRAISAL - CASE MANAGEMENT

As part of the global prenatal/delivery requirements, providers must complete the *Risk Appraisal for Pregnant Women* form. No additional reimbursement will be paid for the completion of the form. Any eligible woman who meets any of the risk factors listed on the form is eligible for case management for pregnant women services and should be referred to a Medicaid enrolled participating case management provider.

NOTE - If you are not billing any of the global prenatal/delivery codes and you complete the *Risk Appraisal for Pregnant Women* form, you may bill for completion of the form using procedure code H1000.

The risk appraisal should be done during the initial prenatal visit or any time after the initial appraisal of a patient originally determined not to be at risk when changes in the patient's medical condition indicate the need.

GLOBAL OB CODES

Code	Description	Medicaid Allowable
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and or forceps), and postpartum care.	$1,075.00
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1,125.00
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps), and post partum care, after previous cesarean delivery	$1,075.00
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	$1,125.00
59425	Antepartum care only, 4-6 visits	$525.00
59426	Antepartum care only, 7 or more visits	$525.00

Billing Tip - To avoid a denial for global delivery code 59400, 59510, 59610, or 59618, if the recipient has more than two visits, you can bill the antepartum code, 59425 or 59426, plus the appropriate delivery code. If the recipient has more than two visits, only the global antepartum will be denied.

Medicaid providers have the option to bill OB services either globally or by individual dates of service. In order to bill globally, all Medicaid guidelines must be met.

OTHER DELIVERY CODES

Code	Description	Medicaid Allowable
59410	Vaginal delivery (with or without episiotomy, and/or forceps) including postpartum care	$550.00
59409	Vaginal delivery only (with or without episiotomy, and/or forceps), no post partum care	$440.00

Code	Description	Medicaid Allowable
59430	Postpartum care only (separate procedure), vaginal delivery	$110.00
59430	Postpartum care only (separate procedure)	$110.00
59515	Cesarean delivery including postpartum care	$600.00
59514	Cesarean delivery only, no post partum care	$480.00
59430	Postpartum care only (separate procedure), cesarean delivery	$110.00
59514-80	Assistant Surgeon, cesarean delivery	$120.00
59612	Vaginal delivery only, after previous cesarean delivery, (with or without episiotomy and/or forceps)	$440.00
59614	Vaginal delivery only, after previous cesarean delivery, with our without episiotomy and/or forceps), including postpartum care	$550.00
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.	$480.00
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care	$600.00

OTHER BILLING REQUIREMENTS

- All claims with global and delivery procedure codes must show the date of the last menstrual period (LMP) in Field 14 on the CMS-1500 claim form.

- If billing a global delivery code or other delivery code, use a delivery diagnosis on the claim, e.g., 650, 669.70, etc.

- If billing a global prenatal code, 59425 or 59426, or other prenatal services, a pregnancy diagnosis, e.g., V22.0, V22.1, etc. is required on the claim.

QUESTIONS AND ANSWERS

The following are questions concerning global OB that are most frequently asked by providers and directed to the Medicaid staff.

Can Medicaid be billed by the same provider for the initial visit in the office for the pregnancy in addition to billing global?

No, all care related to the pregnancy is included in global. The only exception would be if the patient is under the age of 21 and a Healthy Children and Youth (HCY) screen was performed at the initial visit. If this is the case, the provider may bill the HCY screen using V20.2 for the primary diagnosis and a pregnancy diagnosis for the second diagnosis. Then as long as the provider meets all other global o.b. guidelines, the global o.b. codes may be billed as well.

Can the start up of a pitocin drip be billed separately?

No, Medicaid may not be billed for the start up of a pitocin drip. Not only is this procedure included in the global o.b. billing, it is also included in the delivery code if not billing global.

Can obstetrical ultrasounds be billed separately?

Yes, you may bill for ultrasounds when the ultrasounds are medically necessary. Obstetrical ultrasounds are limited to three per calendar year per recipient. If more than three are necessary, the claim must be accompanied by a properly completed Medical Necessity Form documenting the necessity of the procedure. Only one ultrasound is allowed per day. If it is medically necessary to perform a repeat ultrasound on the same day, refer to the CPT for follow-up or repeat procedures.

If the Medicaid patient has received care for her pregnancy by a provider on three different occasions, can another provider still bill global if they have met all the global guidelines?

No, the recipient is allowed two visits to a provider to establish the pregnancy and obtain a referral. If more than two visits to another provider have been reimbursed by Medicaid, the provider of ongoing care must bill out all services separately, i.e., office visits, each urinalysis, hospital visits, delivery, etc.

WILL YOUR PATIENT BE IN A MC+ HEALTH PLAN?

Depending on the area of the state, it is quite possible many of your patients may be required to enroll in a MC+ health plan and choose a primary care provider. Once a patient is enrolled in a MC+ health plan, payment for covered services becomes the responsibility of the health plan. Providers are encouraged to contact health plans to become enrolled as a MC+ provider with the plans.

If a patient becomes enrolled in a MC+ health plan in her third trimester of pregnancy, she may elect to continue to receive her obstetrical services from an out-of-plan provider. The out-of-plan provider must contact the appropriate health plan for instructions. If the out-of-plan provider only has admitting privileges in an out-of-plan hospital, the health plan is obligated to negotiate with the hospital on an agreeable reimbursement schedule.

When a patient receives more than two prenatal visits in a fee-for-service setting and transitions into a MC+ health plan and changes providers, neither provider may bill for a global OB service. In this situation, both providers must bill for each date of service using the appropriate CPT code.

When the obstetrical care begins as fee-for-service and continues with the same provider into a MC+ health plan, the provider must bill for date specific services for each program (Missouri Medicaid and the MC+ health plan). The provider cannot submit a claim for global OB care to either program.

TEMPORARY MEDICAID DURING PREGNANCY (TEMP), MEDICAL ELIGIBILITY (ME) CODE 58 OR 59

The purpose of the Temporary Medicaid During Pregnancy (TEMP) Program is to provide pregnant women with access to prenatal care while they await the formal determination of Medicaid eligibility.

TEMP services for pregnant women are limited to ambulatory physician, clinic, nurse-midwife, diagnostic laboratory, x-ray, pharmacy, and outpatient hospital services. Services other than those listed above may be covered with the attachment of a *Certificate of Medical Necessity* that testifies that the pregnancy would have been adversely affected without the service.

The diagnosis on the claim form **must** be a pregnancy/prenatal diagnosis (V22.0 through V23.9 or V28 through V28.9). Nurse midwives must use diagnosis codes V22.0 through V22.2 or V28 through V28.9.

Inpatient hospital services and deliveries performed either inpatient or outpatient are *not* covered under the TEMP program. Other non-covered services include postpartum care; contraceptive management; D & C; treatment of spontaneous, missed abortions or other abortions.

Infants born to mothers who are eligible under the TEMP Program are **not** automatically eligible under this program.

ABORTIONS AND MISCARRIAGES

Missouri Medicaid does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper CMS-1500 claim form with all appropriate documentation attached. The documentation should include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with one of the following CPT codes: 59200, 59812, 59821, 59830,

CPT codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, and 59866 also require a completed *Certificate of Medical Necessity for Abortion* form in addition to the previously noted documents.